

111TH CONGRESS
1ST SESSION

H. R. 3108

To amend part D of title XVIII of the Social Security Act to promote medication therapy management under the Medicare part D prescription drug program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mr. ROSS introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend part D of title XVIII of the Social Security Act to promote medication therapy management under the Medicare part D prescription drug program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medication Therapy
5 Management Benefits Act of 2009”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) Medications are important to the manage-
2 ment of chronic diseases that require long-term or
3 lifelong therapy. Pharmacists are uniquely qualified
4 as medication experts to work with patients to man-
5 age their medications and chronic conditions and
6 play a key role in helping patients take their medica-
7 tions as prescribed.

8 (2) Nonadherence with medications is a signifi-
9 cant problem. According to a report by the World
10 Health Organization, in developed countries, only 50
11 percent of patients with chronic diseases adhere to
12 medication therapies. For example, in the United
13 States only 51 percent of patients taking blood pres-
14 sure medications are adherent; similarly, only 40 to
15 70 percent of patients taking antidepressant medica-
16 tions adhere to prescribed therapies.

17 (3) Failure to take medications as prescribed
18 costs over \$177 billion dollars annually. The problem
19 of nonadherence is particularly important for pa-
20 tients with chronic diseases that require use of medi-
21 cations; poor adherence leads to unnecessary disease
22 progression, reduced functional status, lower quality
23 of life, and premature death.

24 (4) When patients adhere to, or comply with,
25 their medication therapy, it is possible to reduce

1 higher-cost medical attention, such as emergency de-
2 partment visits and catastrophic care, and avoid the
3 preventable human costs that impact patients and
4 those who care for them.

5 (5) Studies have clearly demonstrated that com-
6 munity-based medication therapy management
7 (MTM) services provided by pharmacists improve
8 health care outcomes and reduce spending. For ex-
9 ample, the Asheville Project—a diabetes program
10 designed for city employees in Asheville, North Caro-
11 lina, and delivered by community pharmacists—re-
12 sulted over a 5-year period in a decrease in total di-
13 rect medical costs ranging from \$1,622 to \$3,356
14 per patient per year, a 50 percent decrease in the
15 use of sick days, and an increase in productivity ac-
16 counting for an estimated savings of \$18,000 annu-
17 ally. Another project involving pharmacist-provided
18 care to patients with high cholesterol increased com-
19 pliance with medication to 90 percent from a na-
20 tional average of 40 percent. In North Carolina, the
21 ChecKmeds NC program, which offers eligible sen-
22 iors one-on-one MTM consultations with phar-
23 macists, saved an estimated \$10,000,000 in
24 healthcare costs and avoided numerous health prob-
25 lems in the first year of the program for the more

1 than 15,000 seniors receiving MTM. Similar results
 2 have been achieved in several other demonstrations
 3 using community pharmacists.

4 (6) Therefore, enhancement of the MTM ben-
 5 efit under part D of the Medicare program should
 6 be a key component of the national health care re-
 7 form agenda.

8 **SEC. 3. IMPROVEMENT IN PART D MEDICATION THERAPY**
 9 **MANAGEMENT (MTM) PROGRAMS.**

10 (a) IN GENERAL.—Section 1860D–4(c)(2) of the So-
 11 cial Security Act (42 U.S.C. 1395w–104(c)(2)) is amend-
 12 ed—

13 (1) by redesignating subparagraphs (C) through
 14 (E) as subparagraphs (F) through (H), respectively;
 15 and

16 (2) by inserting after subparagraph (B) the fol-
 17 lowing new subparagraph:

18 “(C) REQUIRED REVIEWS AND INTERVEN-
 19 TIONS.—Beginning in the first plan year after
 20 the date of the enactment of the Medication
 21 Therapy Management Benefits Act of 2009,
 22 PDP sponsors shall offer medication therapy
 23 management services to targeted beneficiaries
 24 described in subparagraph (A)(ii) that include,

1 at a minimum, the following to increase adher-
2 ence to prescription medications:

3 “(i) An annual comprehensive medica-
4 tion review furnished person-to-person by a
5 licensed pharmacist. The comprehensive
6 medication review—

7 “(I) shall include a review of the
8 individual’s medications, creation of a
9 personal medication record, and a rec-
10 ommended medication action plan in
11 consultation with the individual and
12 the prescriber; and

13 “(II) shall include providing the
14 patient with a written or printed sum-
15 mary.

16 “(ii) Targeted medication reviews fur-
17 nished person-to-person by a licensed phar-
18 macist offered no less frequently than once
19 every quarter to assess medication use
20 since the last annual comprehensive medi-
21 cation review, to monitor unresolved issues,
22 to identify problems with new drug thera-
23 pies or if the individual has experienced a
24 transition in care.

1 “(iii) Followup interventions, which
 2 may be provided person-to-person or
 3 through other interactive means, on a
 4 schedule and frequency recommended by
 5 the prescriber or a licensed pharmacist.”.

6 (b) INCREASE AVAILABILITY OF MTM SERVICES TO
 7 BENEFICIARIES AND INCREASE COMMUNITY PHARMACY
 8 INVOLVEMENT IN PROVISION OF MTM SERVICES.—

9 (1) INCREASED BENEFICIARY ACCESS TO MTM
 10 SERVICES.—Section 1860D–4(c)(2) of such Act (42
 11 U.S.C. 1395w–104(c)(2)), as amended by subsection
 12 (a), is further amended—

13 (A) in subparagraph (A)(ii)(I), by inserting
 14 before the semicolon at the end the following:
 15 “or any chronic disease that accounts for high
 16 spending in the Medicare program including di-
 17 abetes, hypertension, heart failure,
 18 dyslipidemia, respiratory disease (such as asth-
 19 ma, chronic obstructive pulmonary disease or
 20 chronic lung disorders), bone disease-arthritis
 21 (such as osteoporosis and osteoarthritis), rheu-
 22 matoid arthritis, and mental health (such as de-
 23 pression, schizophrenia, or bipolar disorder)”;
 24 (B) by adding at the end of subparagraph
 25 (A) the following new clause:

1 “(iii) IDENTIFICATION OF INDIVID-
2 UALS WHO MAY BENEFIT FROM MEDICA-
3 TION THERAPY MANAGEMENT.—The PDP
4 sponsor shall identify a process subject to
5 the Secretary’s approval that allows phar-
6 macists or other qualified providers to
7 identify enrollees for medication therapy
8 management interventions where such indi-
9 viduals are not described as targeted bene-
10 ficiaries under clause (ii) or are not other-
11 wise offered services described in para-
12 graph (C).”; and

13 (C) by inserting after subparagraph (C)
14 the following new subparagraph:

15 “(D) MEDICATION REVIEWS FOR DUAL
16 ELIGIBLES AND ENROLLEES IN TRANSITION OF
17 CARE.—Without regard to whether an enrollee
18 is a targeted beneficiary described in subpara-
19 graph (A)(ii), the medication therapy manage-
20 ment program under this program shall offer—

21 “(i) a comprehensive medication re-
22 view described in subparagraph (C)(i) at
23 the time of initial enrollment under the
24 plan for an enrollee who is a full-benefit

1 dual eligible individual (as defined in sec-
 2 tion 1935(c)(6)); and

3 “(ii) a targeted medication review de-
 4 scribed in subparagraph (C)(ii) for any en-
 5 rollee at the time of transition of care
 6 (such as being discharged from a hospital
 7 or another institutional setting) where new
 8 medications have been introduced to the
 9 individual’s therapy.”.

10 (c) COMMUNITY PHARMACY ACCESS.—Section
 11 1840D–4(c)(2) of such Act is further amended by insert-
 12 ing after subparagraph (D) the following new subpara-
 13 graph:

14 “(E) PHARMACY ACCESS REQUIRE-
 15 MENTS.—A PDP sponsor shall offer any willing
 16 pharmacy in its network the ability to provide
 17 medication therapy management services to as-
 18 sure that enrollees have the option of obtaining
 19 services under the medication therapy manage-
 20 ment program from community-based retail
 21 pharmacies.”.

22 (d) REIMBURSEMENT AND INCENTIVES BASED ON
 23 PERFORMANCE.—

24 (1) APPROPRIATE REIMBURSEMENT FOR THE
 25 PROVISION OF MTM SERVICES.—Section 1860D–

1 4(c)(2)(H) of such Act, as redesignated by sub-
2 section (a), is amended by striking the first sentence
3 and inserting the following: “The PDP sponsor shall
4 reimburse pharmacists and other entities furnishing
5 medication therapy management services under this
6 paragraph based on the resources used and the time
7 required to provide such services.”.

8 (2) EVALUATION OF PERFORMANCE FOR PAY-
9 MENT INCENTIVES.—Section 1860D–4(c)(2) of such
10 Act (42 U.S.C. 1395w–104(c)(2)) is amended by
11 adding at the end the following new subparagraph:

12 “(I) EVALUATION OF PERFORMANCE.—

13 “(i) DATA COLLECTION AND PRO-
14 VIDER MEASURES.—Effective beginning in
15 the first plan year after the date of the en-
16 actment of the Medication Therapy Man-
17 agement Benefits Act of 2009, the Sec-
18 retary shall establish measures and stand-
19 ards for data collection by PDP sponsors
20 to evaluate performance of pharmacies and
21 other entities in furnishing medication
22 therapy management services. Such meas-
23 ures shall be designed to help assess and
24 improve overall quality of care, including a
25 reduction in adverse medication reactions,

1 improvements in adherence and persistence
2 in chronic medication use, and a reduction
3 in drug spending, where appropriate. PDP
4 sponsors shall also compare outcomes
5 based on the type of entity offering such
6 services and shall ensure broader participa-
7 tion of entities that achieve better out-
8 comes with respect to such services. The
9 measures established under this clause
10 shall include measures developed by the
11 Pharmacy Quality Alliance (PQA) in the
12 case of pharmacist providers.

13 “(ii) CONTINUAL DEVELOPMENT AND
14 INCORPORATION OF MEDICATION THERAPY
15 MANAGEMENT MEASURES IN BROADER
16 HEALTH CARE OUTCOMES MEASURES.—
17 The Secretary shall support the continual
18 development and refinement of perform-
19 ance measures described in clause (i), in-
20 cluding the incorporation of medication use
21 measures as part of broader health care
22 outcomes measures. The Secretary shall
23 work with state Medicaid programs to in-
24 corporate similar performance-based meas-

1 ures into State-required Drug Use Review
2 programs under title XIX.

3 “(iii) INCENTIVE PAYMENTS.—Begin-
4 ning with plan year 2011, pharmacies and
5 other entities that furnish medication ther-
6 apy management services under this part
7 shall be provided (in a manner specified by
8 the Secretary) with additional incentive
9 payments based on the performance of
10 such pharmacies and entities in meeting
11 the quality measures established under
12 clause (i). Such payments shall be made
13 from the Medicare Prescription Drug Ac-
14 count except that such payments may be
15 made from the Federal Hospital Insurance
16 Trust Fund or the Federal Supplemental
17 Medical Insurance Trust Fund if the Sec-
18 retary determines, based on data under
19 this part and parts A and B, that such
20 services have resulted in a reduction in ex-
21 penditures under part A or part B, respec-
22 tively.”.

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